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# Substance Abuse Rehabilitation Program
## Quarterly Self-Assessment Report

Name (please print) _____ Date: _____

SARP Admission Date: _____

***Please complete this Report as stipulated in the Consent Agreement for SARP Participation (CASP) and return it directly to the SARP Coordinator by each scheduled monitoring due date.***

Please list below any changes in your address, name and/ or telephone number:

Name:_____

Address:_____Phone # _____

☐ I have mailed or faxed or emailed my request to change my address to the Board or changed on-line.

☐ I have mailed my request to change my name with legal documentation for the name change to the Board.

1. How many AA/NA meetings are you attending? _____
2. Who is your sponsor and Location of Home Group? _____
3. Have you had any recent medical/surgical/psychiatric problems? Are you taking any new medication(s)?

   [ ] Yes [ ] No Comments:_____

   _____

   _____

4. Have you obtained or changed your primary care physician/provider? [ ] Yes [ ] No

   If yes, Name:_____Address: _____
5. Are you currently employed in Nursing? [ ] Yes [ ] No

   Name and address of current employer(s):_____

   _____Email:_____

   _____

6. Have you changed employers or changed your role in the employing facility since your last self-report?

   [ ] Yes [ ] No If yes, describe _____

   Name and title of supervisor responsible for overseeing your nursing practice: _____

   _____

7. Are you employed outside of nursing? [ ] Yes [ ] No If yes, in what capacity?

   _____

   _____

   _____

8. Describe any major changes in your life: _____

   _____

   _____

9. Describe any problems you are having following your Consent Agreement for SARP participation.

   _____

   _____

10. Describe what progress you have made in your recovery. _____

    _____

    _____

11. Can SARP assist you in anyway? _____

    _____

    _____

_____

**SARP Participant Signature** **Date**